



# The Affordable Care Act

Iowa Insurance Division  
Consumer Assistance Program

# Overview of Training

- Grandfathered Plans: the starting point for ACA issues
- The ACA's Immediate Impact: 2010 ACA Changes
- The ACA's Current Impact: 2011 and 2012 ACA Changes
- What's Coming Next: 2014 ACA Changes
- Q&A

# Grandfathered Plans

- Health plans in existence before March 23, 2010
  - NOTE: for group policies, the date the employee began receiving coverage is irrelevant; it is the date the employer enacted the plan that determines grandfathered status
- Grandfathered plans are exempt from some – not all – provisions of the Affordable Care Act (ACA).
- Plans must include a statement in plan materials stating that it believes it is a grandfathered plan under section 1251 of the Affordable Care Act and provide contact information for questions or complaints.

# Grandfathered Plans

- Examples:

Joe Smith bought a new individual health insurance policy from ABC Insurance Company on October 1, 2010. Joe's policy would be a non-grandfathered individual policy, as it was purchased after March 23, 2010.

Jane Doe signed up for insurance through her employer on January 1, 2009. The employer has had the same insurance policy and has not made any changes to the policy since that time. Jane's policy would be a grandfathered group policy, as it existed prior to March 23, 2010.

Jane Doe began working for her current employer and receiving health benefits from this employer on January 1, 2011. Jane's employer entered into this health policy in 2002 and has not made any changes to the policy since that time. Jane's policy would be a grandfathered group policy, as it existed prior to March 23, 2010.

# Grandfathered Plans

- Grandfathered plans can lose their grandfathered status if they make certain changes to the benefits
- Changes that trigger loss of grandfathered status:
  - Benefit Changes
    - On March 23, 2010 Acme Company's health plan provided benefits for specific mental health conditions which included a combination of counseling and prescription drugs. On July 1, 2010 Acme Company's health plan eliminated benefits for counseling. Does Acme Company's health plan retain its grandfathered status?
      - No. Counseling is a necessary element to treat the condition. The plan is considered to have eliminated substantially all benefits for the treatment of the condition.

# Grandfathered Plans

- Changes that trigger loss of grandfathered status:
  - Changes to Consumer Cost Sharing
    - Coinsurance Increase
      - On March 23, 2010 ABC Company's health plan has a coinsurance requirement of 20% for outpatient laboratory services. In January 1, 2011, the plan is amended to increase the coinsurance to 30%. Does ABC Company's health plan retain its grandfathered status?
        - No. Any percentage increase in coinsurance causes the plan to lose its grandfathered status

# Grandfathered Plans

- Changes that trigger loss of grandfathered status:
  - Changes to Consumer Cost Sharing
    - Copayment Increase
      - On March 23, 2010 AAA Company's health plan has a copayment requirement of \$30 per office visit for specialists. On January 1, 2011, the plan increased the copayment to \$40. The medical inflation rate for the previous 12 months is 7.2%. Does AAA Company's health plan retain its grandfathered status?
        - No. Coinsurance cannot be increased more than 15% plus the medical inflation rate. In this case, the increase of 15% plus medical inflation of 7.2% equals 22.2%. The increase of the copayment is a 33.3% increase which causes the plan to lose grandfather status.

# Grandfathered Plans

- Changes that trigger loss of grandfathered status:
  - Changes to Consumer Cost Sharing
    - Deductible Increase
      - On March 23, 2010 BBB Company's health plan has a \$1000 deductible. On January 1, 2011, the plan increased the deductible to \$2000. Does BBB Company's health plan retain its grandfathered status?
        - No. A plan can increase deductibles by a percentage equal to medical inflation plus 15%. BBB Company increased the deductible by 100%.



# Grandfathered Plans

- Changes that trigger loss of grandfathered status:
  - Changes to Consumer Cost Sharing
    - Employer's Share of the Premium
      - On March 23, 2010 Iowa Company contributed 80% of the total cost of coverage for its employees. On January 1, 2011, the company reduced the contribution to 50%. Does Iowa Company's health plan retain its grandfathered status?
        - No. A company can only reduce its contribution by 5%. Iowa Company reduced the contribution by 30% losing grandfather status.

# Grandfathered Plans

- Changes that trigger loss of grandfathered status:
  - Changes to Consumer Cost Sharing
    - Annual Dollar Limits
      - On March 23, 2010 DSM Company's health plan has a \$1 million annual limit on all benefits. On January 1, 2011, the company reduced the annual dollar limit to \$750,000. Does DSM Company's health plan retain its grandfathered status?
        - No. A plan cannot decrease the annual dollar limit by any amount.

# 2010 ACA Changes

- Young Adult Dependent Coverage
- Preexisting Conditions Exclusions Children Under 19
- Lifetime Dollar Limits
- Annual Dollar Limits
- Rescissions
- Preventive Health Services
- Preserving Doctor Choice and Ensuring Emergency Care
- Grievances and Appeals
- Small Employer Tax Credits
- Preexisting Condition Insurance Plan (PCIP) Program

# Young Adult Dependent Coverage

- Applies to:
  - All plans
- Plans that provide dependent coverage must cover those children up to the age 26 regardless of whether they are married, live with their parents, are students or are financially dependent on their parents.
- Limited exception: Grandfathered group plans do not have to cover adult dependents if they are eligible for employer-based health plan coverage through their own or a spouse's employer. This exception ends January 1, 2014.

# Young Adult Dependent Coverage

- Examples:
  - Bill is age 22 years old, living in an apartment with a roommate and has a full time job. Bill's employer does not offer health insurance. Can Bill stay on his parents grandfathered group health insurance?
    - Yes. Bill can stay on his parent's health insurance until age 26 years old.
  - Bill's employer begins offering health insurance on January 1, 2012.
    - Bill is no longer eligible to stay on his parent's health insurance as he now has access to coverage through an employer-sponsored health plan.

# Preexisting Condition Exclusions for Children Under the Age of 19

- Applies to:
  - All plans except Individual grandfathered plans
- Pre-existing condition exclusion means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage whether or not any medical advice, diagnosis, care or treatment was recommended or received.
- However, individual insurance policies can restrict the enrollment of children under 19 to a specific enrollment period.

# Preexisting Condition Exclusions for Children Under the Age of 19

- Example:

Mr. and Mrs. Wilson purchase a new family insurance plan in October 2010 and enroll themselves and their two children, 3-year-old Emma and 8-year-old Bob, in the plan. Emma has diabetes. Because the Wilsons have purchased a new plan, their family is protected under the new law. The plan is not allowed to exclude coverage of Emma's preexisting condition; therefore, Emma will receive treatment for her diabetes as soon as their coverage begins.

The Patients' Bill of Rights: Ensuring Coverage for Consumers with Pre-Existing Conditions, *available at* <http://www.familiesusa.org/health-reform-central/september-23/Pre-Existing-Conditions.pdf>

# Annual and Lifetime Limits

- *Elimination of Lifetime Limits Applies to:*
  - All plans
    - Prohibits lifetime limits on essential benefits.
- *Phase Out of Annual Limits Applies to:*
  - All plans except grandfathered individual plans.
  - Prohibits annual dollar limits on essential benefits, phased in until January 1, 2014.
    - \$1.25 million for plan years beginning 9/23/2011 – 9/23/2012
    - \$2 million for plan years beginning 9/23/2012 – 12/31/2013



# Annual and Lifetime Limits

- Lifetime Dollar Limit Example:

Sally Smith was previously enrolled in HealthStar Insurance through her employer. Before the new law was passed, HealthStar Insurance had a lifetime limit of \$1 million. One year ago, Sally was diagnosed with cancer that was at an advanced stage. She needed chemotherapy and invasive surgery, as well as extensive follow-up treatments. In less than a year, Sally reached her \$1 million lifetime limit, and her insurance stopped covering her medical bills. Sally had to turn to friends and family to help her pay for the remainder of her cancer care.

Under the new law, HealthStar Insurance will be required to remove its lifetime coverage limit. The HealthStar Insurance new plan year begins on January 1, 2011. By that date, HealthStar Insurance must notify Sally that she can reenroll in her employer's plan, and it must give her at least 30 days to do so.

# Rescissions

- Applies to:
  - All plans
- Rescission = retroactive cancellation, as if consumer never had the policy
- May not rescind coverage except in the case of fraud or intentional misrepresentation of material fact.
- Cancellation of coverage is allowed for failure to pay timely the required premiums or contributions towards the cost of coverage.

# Rescissions

- Example:

When her insurance application asked for “anything else relevant to your health that we should know about,” Katy forgot to mention two visits to a psychologist she had 6 years earlier. Katy was later diagnosed with breast cancer and submitted claims to her insurance company for breast cancer treatment. After receiving Katy’s claim, her plan discovered the two psychologist visits. Before the new law, Katy’s mistake might have prompted her health insurer to rescind (retroactively cancel) her coverage. But under the new law, Katy’s insurance plan cannot rescind her coverage, because Katy did not intentionally misrepresent significant information.

Healthcare.gov website, *available at*,

<http://www.healthcare.gov/law/provisions/Curbing%2oInsurance%2oCancellations/cancellations.htm>  
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# Coverage of Preventive Health Services

- Applies to:
  - All non-grandfathered plans
- Must cover certain preventive services without cost-sharing.
- BUT plans that have network providers can impose cost-sharing for preventive services delivered by out-of-network providers.
- Preventive services include routine preventive screening for adults , screenings for women, and immunizations and preventive screenings for infants, children and adolescents.

# Coverage of Preventive Health Services

- Examples:
  - Routine preventive screening for adults;
    - Examples include blood pressure, tobacco and cancer screenings
  - Immunizations and specified preventive care and screening for infants, children and adolescents
    - Examples include hearing and vision screenings
  - Preventive care and screenings for women, including pregnant women
    - Examples include mammograms and counseling to ensure healthy pregnancies

# Preserving Doctor Choice

- Applies to:
  - All non-grandfathered plans
- Policies that require a designation of a primary care provider must allow the choice of any participating primary care physician that accepts new patients, including pediatricians.
- May not require prior authorization or referral for women to see an in-network OB-GYN.

# Preserving Doctor Choice

- Examples:
  - Mr. Y enrolls in Best Insurance, a new plan offered through his employer. Mr. Y receives a notification from Best Insurance that explains how, under the new law, he may select one of the 800 primary care providers in the Best Insurance provider network as his primary care provider. If Mr. Y doesn't designate a primary care provider of his choice, Best Insurance will pick one for him.
  - Suzie Q enrolls in a new health plan from Healthy Life Insurance. Following the plan's requirements, Suzie Q selects her primary care provider from the Healthy Life Insurance provider network. Suzie Q then schedules an appointment with Dr. A, an in-network OB/GYN. Because Dr. A is in the Healthy Life Insurance network, she does not need a referral from her primary care provider or prior authorization from the insurance company.

The Patients' bill of Rights: Ensuring the right to Choose Your Doctor, *available at*  
<http://www.familiesusa.org/health-reform-central/september-23/Choosing-your-Doctor.pdf>

# Ensuring Emergency Care

- Must cover emergency services provided by a non-participating provider, with or without prior authorization, in the same manner as they would a participating provider
- BUT out-of-network provider is free to “balance-bill” consumer for what insurance does not cover



# Ensuring Emergency Care

- Example
  - Bob and Mary were on a road trip from Iowa to Arizona. While driving through Colorado, Bob suffered a massive heart attack and was rushed to the emergency room of a hospital outside of his insurance's network
  - Bob's insurance must pay the Colorado hospital the same amount it pays to in-network hospitals for the services he received.
  - Bob's hospital bill totaled \$10,000. The insurance paid its in-network rate, \$7,000. The hospital has the right to balance bill Bob directly for \$3,000.

# Grievance and Appeals

- Applies to:
  - All non-grandfathered plans
- Internal Appeal
  - Adverse determination must be provided in a reasonable amount of time, in a culturally and linguistically appropriate manner, and free of charge.
  - For on-going treatment, health insurance companies must provide advanced notice and opportunity for appeal before terminating or changing coverage for the treatment.
  - If all requirements are not strictly adhered to the individual can move directly to external review.

# Grievance and Appeals

- Internal Appeal- continued
  - Denial of non-urgent care not yet received must be decided within 30 days.
  - Denial of claims of services already received must be decided within 60 days.

# Grievance and Appeals

- External Review
  - Health insurance company must provide written notice of external review rights.
  - No minimum dollar amounts
  - Individuals have four months from final internal appeal denial to file an external review.
  - Must be reviewed by an independent review organization (IRO).
  - Must allow for expedited review of urgent care situations.
  - The IRO decision is binding on Insurance company, but individuals have 15 days after receiving the IRO decision to file an appeal in Polk County District Court, or the district court of the county in which they reside.

# Grievance and Appeals

- External review – 2 types
  - Standard (majority of reviews)
    - IRO has 45 days to issue decision
  - Expedited
    - Physician must certify that waiting for internal appeals and/or standard external review would have one of these effects:
      - Seriously jeopardize the patient's life, health, or ability to regain maximum function
      - The experimental/investigational treatment would be significantly less effective if not promptly initiated
    - IRO has 72 hours to issue decision

# Small Employer Tax Credits

- Some small employers are eligible for tax credits up to 35% to offset the cost of health insurance until 2014.
- The credit is available to employers who meet all 3:
  - Cover at least half of the insurance premiums for employees;
  - Have no more than 25 full-time employees; and
  - Pay average annual wages of less than \$50,000.
- Beginning in 2014, tax credits increase to 50%.
- Non-profit organizations tax credits are 25% until 2014 when it will increase to 35%.

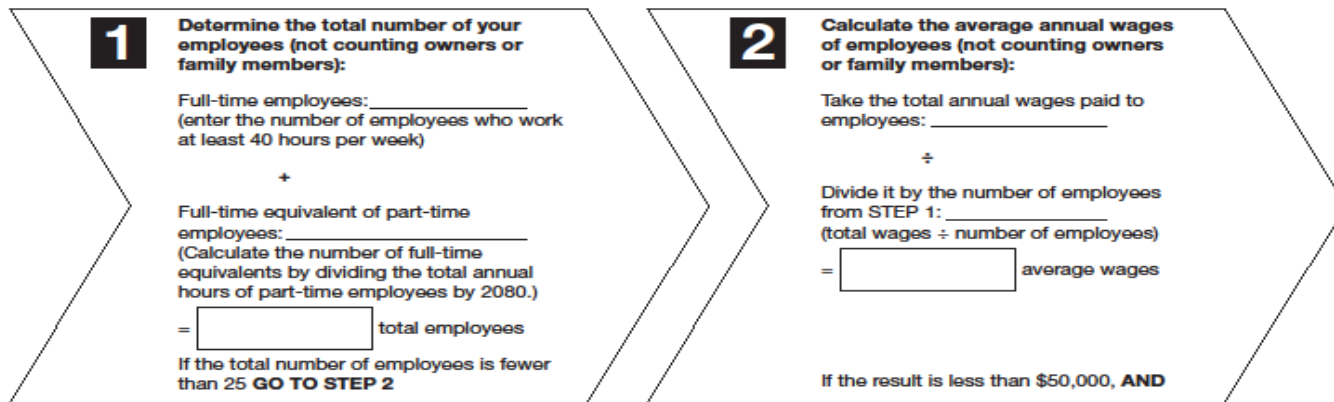
# Small Employer Tax Credits

- Examples:
  - Example 1 : Auto Repair Shop with 10 Employees Gets \$24,500 Credit for 2010  
Main Street Mechanic:
    - Employees: 10
    - Wages: \$250,000 total, or \$25,000 per worker
    - Employer Health Care Costs: \$70,0002010 Tax Credit: \$24,500 (35% credit)  
2014 Tax Credit: \$35,000 (50% credit)
  - Example 2 : Restaurant with 40 Part-Time Employees Gets \$28,000 Credit for 2010  
Downtown Diner:
    - Employees: 40 half-time employees (the equivalent of 20 full-time workers)
    - Wages: \$500,000 total, or \$25,000 per full-time equivalent worker
    - Employer Health Care Costs: \$240,0002010 Tax Credit: \$28,000 (35% credit with phase-out)  
2014 Tax Credit: \$40,000 (50% credit with phase-out)

# Small Employer Tax Credits

## 3 SIMPLE STEPS

If you are a small employer (business or tax-exempt) that provides health insurance coverage to your employees, determine if you may qualify for the **Small Business Health Care Tax Credit** by following these three simple steps:



**3** You pay at least half of the insurance premiums for your employees at the single (employee-only) coverage rate, then

» you may be able to claim the **Small Business Health Care Tax Credit**.  
Find out more information at **IRS.gov**





# Preexisting Condition Insurance Plan (PCIP) Program

- Established for individuals who have been uninsured for 6 months due to preexisting condition.
- Must be a United States Citizen or lawfully residing in the United States.
- Iowa's PCIP program: HIPIOWA-FED
  - Do not confuse with HIPIOWA – different program created under HIPAA
- Hospital care, primary and specialty services, and prescription drug.
- Ends 2014 with implementation of Exchanges.

# 2011 and 2012 ACA Changes

- Medical Loss Ratios
- Use of Standard Definitions and Uniform Explanation of Coverage Documents

# Medical Loss Ratios (MLR)

- Effective for plan years beginning 1/1/11
- MLR = percentage of premium dollars spent on health claims and quality of care improvements.
- Individual and small group market MLR 80%
- Large group market MLR 85%
- Insurance companies that exceed the MLR must provide rebates to each policyholder
  - If you have insurance through your employer, your employer gets the rebate, not you

# Use of Standard Definitions and Uniform Explanation of Coverage Documents

- Beginning September 23, 2012, must provide summary of benefits and coverage explanation including:
  - Definitions of standard insurance and medical terms
  - Description of cost sharing
  - Exceptions, reductions and limitations of coverage.
- Must be “Culturally and linguistically appropriate” so it is easily understood
- Designed to help consumers compare different plans easily

# 2014 ACA Changes

- Extension of Guaranteed Issue to all Markets
- Guaranteed Renewability Nationally
- Rate Restrictions in the Small Group and Individual Markets
- Coverage Eligibility Waiting Periods Not to Exceed 90 Days
- Coverage of Clinical Trials
- Limitation on Out-of-Pocket Costs and Deductibles
- Tax Credits for Individuals and Families
- Individual/Employer Insurance Coverage Requirements

# Extension of Guaranteed Issue to all Markets

- Applies to:
  - All non-grandfathered plans
- No longer allowed to deny coverage based on preexisting condition.
- Limitations on Protection
  - insurers can exclude coverage of services that are not deemed part of the “minimum essential coverage” (see below)
  - Insurers will be able to limit enrollment to an open enrollment period.
  - Insurer will be able to adjust plan charges based on the characteristics of the individual.

# Guaranteed Renewability Nationally

- Applies to:
  - All non-grandfathered plans
- All health insurance must be renewable at the option of the plan sponsor or the individual.
- Exceptions:
  - In cases of fraud;
  - Unpaid premiums;
  - Individual moves out of coverage area; or
  - Insurer withdraws entirely from the market.

# Guaranteed Renewability Nationally

- Example:

Jane Smith is enrolled in a group health plan insurance policy with ABC Company. The policy has a contract clause that states the policy terminates when one becomes eligible for Medicare. The clause is not valid and is not enforceable since it violates the guaranteed renewability requirement.



# Rate Restrictions in the Small Group and Individual Markets

- Limited variation in premiums in small and individual market for the same plan.
- Individual premiums may vary on only four factors:
  - Whether coverage is for an individual or family;
  - Where the Insured lives;
  - Age, may not vary more than 3 to 1; and
  - Tobacco use, may not vary more than 1.5 to 1.
- Gender-based premium differences will no longer be legal
- BUT, premium base rates increases are not affected by this provision. Base rate characteristics include:
  - Loss ratio for the entire group
  - Medical inflation
  - Drug cost

# Coverage Eligibility Waiting Periods Not to Exceed 90 Days

- Applies to:
  - All group health plans
- Waiting period refers to period of time that must pass before the benefits are paid.
- Waiting period cannot exceed 90 days.
- Group health plans can impose waiting periods to new participants.
- Must be applied uniformly to all participants.

# Coverage Eligibility Waiting Periods Not to Exceed 90 Days

- Example:

Jane Smith joined company ABC on April 27<sup>th</sup> .  
Company ABC's group health plan imposes a 3-month waiting period for everyone enrolling in the plan.  
Immediately upon being hired, Jane completed and filed all forms necessary to enroll in the plan. Coverage is effective 90 days later.

# Coverage of Clinical Trails

- Must cover routine patient costs for approved clinical trials for life-threatening conditions.
- Must cover all items and services consistent with the coverage provided by the Insured's plan.

# Limitation on Out-of-Pocket Costs

- Annual limits on out-of-pocket costs which includes:
  - Deductibles
  - Co-insurance
  - Co-payments
  - Other qualified medical expenses
- Does not apply to:
  - Premiums
  - Balance billing amounts for non-network providers
  - Spending for non-covered services

# Tax Credits for Individuals and Families

- Available for those with income between 100 and 400 percent of the poverty line.
  - 2011, 400 percent is approximately \$43,000 for an individual
- Cannot be eligible for Medicare or Medicaid
- Can be refunded at tax time or taken in advance
- Used to lower monthly premium payments

# Individual/Employer Health Insurance Coverage Requirements

- Beginning January 1, 2014 all individuals must be enrolled in a health insurance plan.
- Health insurance coverage must include “minimum essential coverage”.
- Tax penalty for those without health insurance.
- Exemptions include individuals who are:
  - Low income;
  - Prohibited by religious beliefs;
  - Incarcerated;
  - Not legally present in the United States
  - Unable to obtain affordable coverage ( $\leq 8\%$  of income)

# The Establishment of Health Insurance Exchanges

- One-stop shopping
- Functions of Exchanges include:
  - Offer toll-free hotline and website presenting health plan information in a easy to understand format;
  - Assign quality and price ratings for each plan offered;
  - Provide information about Medicaid, CHIP and other State or local programs including enrolling eligible individuals to these programs;
  - Electronic calculator to determine “actual” post-tax cost of coverage; and
  - Grant certification to individuals that are exempt.



# The Establishment of Health Insurance Exchanges


- States can establish two exchanges or combine into one exchange.
  - Individual
  - Small business health care option program (SHOP)
- SHOP Exchanges
  - Businesses with 1 to 100 employees.
  - Until 2016 can limit to businesses with 50 or fewer employees.
  - Beginning 2017 States may allow businesses with over 100 employees to use the Exchange to purchase coverage.

# The Establishment of Health Insurance Exchanges

- Navigator Program – exchanges will give grants to groups who have relationships with consumers, like
  - Chambers of commerce
  - Unions/trade organizations
  - Ranching and farming organizations
- Navigator Responsibilities
  - Public education
  - Distributing impartial information
  - Facilitating enrollment
  - Referrals to State agencies

# Minimum Essential Coverage

- Ambulatory care
- Emergency services
- Hospitalization
- Preventive and wellness services and chronic disease management
- Laboratory services
- Prescription drugs
- Maternity and newborn care
- Pediatric services
- Mental health and substance use disorder services
- Rehabilitative and habilitative services and devices



# Thank You

# Questions?

Angel Robinson  
Consumer Advocate  
Consumer Assistance Program Director  
Phone: 515-281-4038  
Email: [angel.robinson@iid.iowa.gov](mailto:angel.robinson@iid.iowa.gov)  
Website: [insuranceca@iid.iowa.gov](mailto:insuranceca@iid.iowa.gov)